

working well  
newsletter  
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Issue 16

mcwh: putting immigrant & refugee  
women's health first!



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& their impact on  
young women

Multicultural Centre for Women's Health is an immigrant and refugee women's organisation committed to improving the health and wellbeing of immigrant and refugee women across Australia.

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mcwh professional training goes to tasmania

MCWH recently conducted three days of cross-cultural training in Hobart, focusing on immigrant and refugee women and sexual and reproductive health. Women's Health South Tasmania organised and funded this event, which was designed for people working with immigrant and refugee women. Training took place between March 17 and 19 2009.

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Around 35 representatives from government and non-government organisations in Tasmania participated. They included participants from: Women's Health South, Royal Hobart Hospital, Family Planning, Anglicare, Family Violence Support Services, Youth Pulse Centre, Centrelink, Cancer Screen, Red Cross, Hobart Women's Health Centre and Sexual Health. The training program consisted of six modules which were delivered over three days.

Module 1 'Communication with Immigrant and Refugee Clients' and Module 2 'Using Interpreters and Bilingual Health Educators in Sexual and Reproductive Health Services' were covered in the first day of the training.

Module 1 focused on the communication process and how culture can have a vital impact on communication. Other topics covered in this session included barriers to communication and strategies for effective communication.

In Module 2 the discussion centred on the effective use of interpreters, this included assessing when an interpreter is needed in communicating with immigrant and refugee women; the differences between bilingual health educators and interpreters; and when it is more effective to use a bilingual health educator rather than an interpreter, and why.

The second day included Module 3 'Building Trust with Immigrant and Refugee Clients' and Module 4 'Cultural Awareness in Sexual and Reproductive Health'.

Module 3 covered the following issues: identifying and understanding the factors that cause immigrant and refugee women to lose trust in sexual and reproductive health services and the consequences for service provision; understanding the barriers which affect immigrant and refugee women's access to appropriate care in mainstream services; and developing strategies to gain and build trust.

Module 4 dealt with developing participants' awareness and knowledge of the different beliefs and practices of immigrant and refugee women in relation to sexual and reproductive health, and recognising the importance of this awareness in being responsive to women of diverse backgrounds. The training also covered traditional practices affecting immigrant and refugee women's health with a focus on female genital mutilation (FGM). Diverse understanding of health was also discussed making use of various case studies. Strategies for a more culturally sensitive approach to health service provision were also outlined.

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	<p>The final day's training covered Module 5 'Isolation and Immigrant and Refugee Women' and Module 6 'Health Service Provision for Immigrant and Refugee Women'.</p>
<p>amharic arabic cantonese croatian dari english farsi greek hindi italian</p>	<p>Module 5 provided the main themes and terms associated with working with women from immigrant and refugee communities; it also discussed the impact of migration and resettlement on immigrant and refugee women's health; and addressed the impact of culture on health beliefs and practices in the context of health service provision. Strategies for developing more inclusive services were also covered.</p> <p>Module 6 was the final session in the training. Participants discussed their organisation's work with immigrant and refugee women and challenged the widely accepted practices in mainstream services relating to the provision of health services to immigrant and refugee women. They also addressed the importance of providing relevant, culturally and linguistically sensitive information to immigrant and refugee women. The session ended by looking at MCWH's programs and activities and our successful model of using Bilingual Health Educators in conducting multilingual health education sessions in various workplace and community settings.</p> <p>MCWH successfully achieved its objectives in delivering this training program. Feedback from participants was very positive.</p> <p>dr salma al-khudairi education and training officer</p>

	<p>visiting women in cleaning &amp; support services</p>
	<p>Multicultural Centre for Women's Health is well known amongst our members, supporters and most importantly amongst women, as the organisation that provides multilingual health education sessions to immigrant and refugee women in the community and in the workplace.</p> <p>Since 1978 we have visited hundreds of workplaces where immigrant and refugee women work to ensure they possess the information they need to control their health and wellbeing. Throughout the period 1970-1990 the majority of immigrant and refugee women worked in textile clothing and footwear (TCF) industries and accordingly MCWH focused on these workplaces. Working in TCF industries kept us busy for decades.</p> <p>MCWH has always kept a close eye on workforce movement especially in relation to immigrant and refugee women. By the late 1990s the textile clothing and footwear industries were undergoing huge upheaval and many immigrant and refugee women moved to the food industries sector. In part, this movement was due to TCF industries restructuring or moving offshore which found many immigrant and refugee women being retrenched, being made redundant or working on a casual basis.</p> <p>Environmental changes in relation to work availability are a key consideration in MCWH strategic planning, specifically in planning our response to its impact on immigrant and refugee women. Within this context, MCWH engaged Associate Professor Santina Bertone and Dr Beata Leuner (both from Victoria University),</p>
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to research where immigrant and refugee women were now working. Their research established that immigrant and refugee women were moving into new employment sectors including the back-of-house departments in large hotels, environmental services departments of major hospitals, contract cleaning agencies, and mail sorting centres.

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This research included consultation with management at the Langham, Sofitel and Grand Hyatt hotels and also at Crown Casino. The Royal Women's Hospital and Royal Children's Hospital were also consulted. Other research participants included the Communications Workers Union, the Liquor, Hospitality and Miscellaneous Workers Union, VicHealth, the Victorian Multicultural Commission, the ECCV, and the Victorian Equal Opportunity and Human Rights Commission. This research took place between November and December 2007.

The highest numbers of immigrant and refugee women are now working in the health care and social assistance, retail and manufacturing sectors. Most immigrant and refugee women working in hotels and hospitals were found to be employed in low-skilled jobs such as patient service attendants, as cleaners, laundry hands, room attendants, and in back-of-house positions. Women in these industries come from the Philippines, Vietnam, China, India, Malaysia, Sri Lanka, and Thailand and recently from the Horn of Africa (Sudan), and the Middle East (Iraq, Iran). There are also women from Russia, South America, Nepal, Romania, Greece, the former Yugoslavia and Poland.

Our first program in the hotel industry will take place in July-August 2009 at The Langham Hotel, Southgate Melbourne. The Langham employs a staff of 350 people. One hundred and twenty of its employees are from immigrant and refugee background, eighty per cent of which are women. The major cultural and language groups of these employees are Portuguese, Filipino, Indian, Chinese, Sri Lankan, Vietnamese and Thai. MCWH's Bilingual Health Educators (including Educators with these language and cultural backgrounds) will be working with restaurant, housekeeping, and support staff. I would like to acknowledge the productive and encouraging meeting I had with the Langham's HR Manager Andrea Horrell who is very enthusiastic about addressing the specific health education needs of the Langham's immigrant and refugee women employees.

We are looking forward to conducting our Industry Visits Program at the Langham and bringing our health education sessions to the hotel industry. We are also looking forward to the fresh opportunities and challenges that come with engaging a new workplace sector. Look out for future reports regarding our progress, the major issues women in this industry raise, and how MCWH is addressing them.

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manager education & training  
programs

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## traditional practices & their impact on young women

The following feature is based on a guest speaker address originally presented by Professor Manderson at the February 26 2009 MCWH Seminar 'Traditional Practices Affecting Young Immigrant and Refugee Women's Health and Wellbeing'.

by Professor Lenore Manderson  
Monash University

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### introduction

Traditions are ways of sharing knowledge and wisdom, reinforcing group identity, and establishing bonds within communities. They are ways for members of communities to get together, to consolidate networks and create new ties, and they are ways to celebrate belonging. A few traditions create difficulties, however, both because they can affect individuals in negative ways, physically and psychologically, and because their practise is contrary to the law in country of origin and, for immigrants, in country of resettlement.

### traditional cultural practice & marriage

*Arranged marriages and early age at marriage* are common in many cultural settings, and young women may experience great conflict with their parents if they wish to make their own decisions about when and if to marry, and if so, to whom. Although the effects of arranged marriage are especially emotional and psychological, early arranged marriages result in young women having to leave school early. We know that women's educational status is linked to economic development, a woman's health status, and the health of her children. It is therefore important to all societies that women maximise their educational opportunities and capacity.

### early marriage: sexual & legal implications

Where early marriage is accompanied by sexual intercourse, either from the time of the marriage or with first menstruation, young women are forced to commence a sexual relationship before they are emotionally or physically ready. Forced sex within marriage is a criminal act in Australia, that is, rape within marriage is illegal. The tissue of the vaginal wall is thinner for young women compared with older women, and forced sex (and rough or dry sex) can result in vulval and vaginal lesions, associated pain, and psychological trauma. Women are also more vulnerable to trauma when there is a preference for dry sex, and so penetrative intercourse occurs without adequate natural lubrication. In addition, some women use astringent agents to dry their vaginas. As a result of tears and lesions, young women are at increased risk of sexually transmissible and reproductive tract infections, of which the most common in Australia—Chlamydia—can cause pelvic inflammatory disease, chronic pelvic pain, and infertility or subfertility. Human papilloma virus is also prevalent in Australia, and it is a primary cause of cervical cancer.

### early use of contraception and early pregnancy: long-term impacts?

The long term effects of *early contraceptive use* are not known. Condoms, while protecting women against sexually transmissible infections and pregnancy, may also result in trauma (tears) on the vulva and vagina in young women. Extended use of chemical methods of contraception—the contraceptive pill or an injectible or implant, as would occur if young women delay pregnancy for some years—can cause temporary infertility, and the longer term effects of oral contraception are even more problematic.

*Early age at pregnancy* is often encouraged because of the importance to families and communities to ensure heirs. However, there are a number of health implications when young women conceive before they have fully matured. These women may not reach their potential full height, and may suffer from anaemia, affecting their own health and that of their unborn child. Young women are more likely than women at any other age to experience a common serious disorder of pregnancy, to suffer miscarriage, to experience difficulties in labour, and to have higher than normal rates of low birth weight babies. Low birth weight babies, in turn, are more likely than other babies to have poor health, experience development delays, and suffer from longer term health problems.

### traditional marriage practices: genetic implications

*Marriage between cousins* is common in certain communities. This practice increases the transmission of genetic conditions. For example, the marriage of cousins (common among people from West Asia, for example) results in a much higher risk than the general population of their children having genetic illnesses such as thalassaemia, sickle cell anaemia and related conditions.

### female genital mutilation: health, education & economic prospects

*Female genital surgery* (most commonly referred to as female genital mutilation or FGM) is the most widely known example of a traditional practice that contravenes both international law and the laws of most countries. The surgery is undertaken in communities in Sudan, Egypt and the Horn of Africa, but also in other sub-Saharan countries, although a minor procedure is also common among Moslem communities in Indonesia and Malaysia. However, it is neither mandated nor commended by Islam, and in parts of Africa, forms of surgery also occur among Christian populations. Surgery can vary in its extensiveness and by age when it is conducted.

The impact of FGM on young women varies depending on age and severity of cutting, and while it affects young women, the effects continue throughout women's lives.

These include the traumatic memories of the pain associated with the surgery, and the processes leading up to the surgery. Women may experience health concerns such as infections and haematomas which if unaddressed can lead to disruptions to school attendance and consequently poor results, and can compromise the employment of women out of school.

Female genital surgery can also inhibit sexual function. In some cases women report that they are able to experience sexual pleasure but this is not true in all cases. In addition, for some women who have had this surgery, first sex can be very painful and sex may always be painful.

In Australia, pregnant women who have been infibulated are advised to be de-infibulated well before child birth. Women often then complain about acute sensitivity of their labia, and are distressed by the difference in urinating once de-infibulated. These factors contribute to the requests by some women to be re-infibulated after childbirth. Re-infibulation is illegal and recurrent de- and re-infibulation for women with each

## main feature

pregnancy and birth increase scarring, pain and infection. Without de-infibulation to open the birth canal, there is an increased risk to both women and their unborn infants, and childbirth might take a longer period of time. Foetal distress may not be monitored as quickly (through meconium staining, for instance), and any complication at time of delivery will necessarily require caesarean section.

## cultural practice, isolation & the impact on women's health and social participation

*The seclusion of young women both by the clothes they wear, such as heavy veils and heavy long-sleeved and full length clothes, and by keeping them indoors, also compromises their health. Firstly, Vitamin D is critical for bone health, and is implicated therefore in conditions such as rickets. Women who are secluded have inadequate sunlight, the primary source of Vitamin D, and so are at greater than normal risk of such conditions, and of depression. Women may also experience greater than normal rates of skin irritations, such as rashes and infections.*

Where women are secluded and prevented from social participation, physical exercise is difficult. Women who have poor physical fitness are more likely to tire easily and to gain weight. Being physically active may contribute to young women's confidence, where they are involved in team sports they gain the ability to work with others, and by being active, are less likely to be bored, isolated and potentially depressed. Exercise may also reduce premenstrual tension and counter stress.

In societies where people were responsible for their own food production and processing, fatness was highly desirable, implying wealth. Plump young women were assumed to be especially fertile. But in urban industrial societies, most women and men do not work hard enough to burn off excess calories, and weight gain is permanent. The increase in overweight and obesity is largely determined by an inappropriate diet, including too much food with high energy value, and by lack of exercise.

## main feature

The development of diabetes mellitus (type 2 diabetes) is increasing worldwide, and this in turn affects women's health in pregnancy, and for both women and men can, if uncontrolled, affect vision, kidney function and circulation.

## impact of presentation

Professor Manderson's presentation provided participants with expert and insightful information regarding traditional practices and their impact on immigrant and refugee women. It also provided considerable material for discussion and debate. Discussion and debate was also enriched by participants presenting relevant case studies from their own work and experiences, and other exchanges of information and experiences by those working with immigrant and refugee women.

Questions were raised around the impact of beliefs and traditions on immigrant and refugee women's health. Various case studies were presented by community workers and refugee nurses who work with immigrant and refugee women. These case studies explored the impact of traditions, religion and other cultural factors influencing early marriage, forced marriage, sexual abuse, and FGM. They recommended more practical approaches addressing traditional practices in a sensitive manner including cross-cultural education and working with bilingual health educators. They also recommended empowering women affected by traditional practices which impact on their health, by providing education about the health system in Australia and related resources.

Other participants asked for more educational seminars relating to this topic including more information on the resources available to young immigrant and refugee women and also to service providers.

MCWH received very positive feedback regarding the seminar and participants looked forward to future seminars in this area.

mcwh presents at fecca/eccwa conference	
	In 2009 the Federation of Ethnic Communities Councils of Australia (FECCA), in conjunction with the Ethnic Communities Council of Western Australia (ECCWA), hosted a national conference on immigrant and refugee women under the theme: 'setting the social inclusion agenda.' The conference was combined with International Women's Day.
amharic	Adele Murdolo and I represented MCWH at the conference. It was an excellent opportunity for us to showcase our work in advancing the social inclusion agenda. We did a joint presentation on the Points of Departure National Advocacy Project. The conference was a good networking opportunity, as new partnerships were forged, and existing ones strengthened. It also provided an opportunity to promote MCWH's advocacy work and other activities. Most importantly, for the Points of Departure Project, we took time to meet with members of the expert advisory committee (EAC) who were present, to confer and to get members' thoughts about the National Forum which was due to take place the following month.
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	In talking about social inclusion, age is as important a determinant as gender, ethnicity, or literacy.
	Speakers were drawn from different backgrounds —reflecting the diversity of issues affecting immigrant and refugee women. Speaker after speaker reiterated the positive contribution of immigrant and refugee women to the social and economic development of Australia, yet women continue to face a lot of disadvantages due to their ethnicity, gender, and cultural diversity. Social and political participation; labour force participation; and representation issues were some of the topics covered by the presentations.
	The theme of the conference 'setting the social inclusion agenda,' complemented the efforts of Government, which is currently implementing a social inclusion agenda to help achieve better outcomes for all Australians, including immigrant and refugee women. A member of the Government appointed Social Inclusion Board present at the conference, helped shed more light on the work that is underway to address issues of disadvantaged groups. This political will is further reflected in the conference messages sent to the conference organisers by senior government officials, in which pledges were made to support the ongoing work of women's organisations in ensuring the inclusion of immigrant and refugee women in all spheres of life. I end this report with a quote from the conference presentation, 'The Power of Punctuation': 'Woman, without her man, is nothing.' 'Woman: without her, man is nothing.' (Anon)
	dr pauline gwatirisa national project and advocacy officer

#### ✦ subscribe to working well

'Working Well' is the Multicultural Centre for Women's Health newsletter. Keep up-to-date with projects and programs and the issues affecting immigrant and refugee women's health and wellbeing. Contact us and we will put you on the mailing list.

#### ✦ be well read about immigrant & refugee women's health and wellbeing

If you would like to be well read about immigrant and refugee women's health contact us for a mcwh publications catalogue. For research reports on a wide range of immigrant and refugee women's issues including resettlement, sexual and reproductive health, occupational health and safety, alcohol and other drugs and the impact of gambling on immigrant and refugee women.

#### ✦ access multilingual health information

Become a MCWH Member and borrow resources from the Multilingual Library. We also have a comprehensive Resource Collection if you are looking for information in your language. Over 12,000 items and almost 70 languages.

#### ✦ enhance your work with immigrant & refugee women

MCWH provides cross-cultural and other specific training for employers, community workers, service providers and health professionals—we specialise in intensive training programs for bilingual community workers. MCWH will customise our training to your needs.

#### ✦ join mcwh

If you are interested in immigrant and refugee women's health and wellbeing, become part of MCWH, contact us for a MCWH membership form.

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